Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH CARE PLLC
2821 LACKLAND SUITE 300
FORT WORTH TEXAS 76116

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN MOTORISTS INSURANCE CO

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-05-2014-01

MFDR Date Received
November 15, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is believed that your organization incorrectly denied or reduced the claim/service in question for the following reasons: The services were denied as a duplicate. The services were submitted as an appeal to the denial previously received for no authorization. The claim had a cover letter stating this, request for reconsideration stamped on claim, as well as the EOB previously received. As noted on the previous appeal injections performed in the office do not require preauthorization per the TWCS guidelines. I have attached the claim for reconsideration, dictation, and both EOB received."

Amount in Dispute: $4,815.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is carrier's position that the provider, Texas Health Care didn't file bills timely and therefore bills were denied based on the 11 month rule."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2003	27096, S0020 (J3490), J1030, and A4550	$1,219.00	$0.00
February 21, 2004	27096-50, 76005, S0020 (J3490), and J3301	$3,596.00	$1,002.23

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute filed on or after January 1, 2002.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services provided on or after September 1, 2002.
3. Division rule at 28 TAC §134.1, effective May 16, 2002, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.

Issues

1. Did the requestor submit the DWC060 for date of service April 18, 2003 within the one year filing deadline and is April 18, 2003 eligible for a Medical Dispute Resolution Review?
2. Did the requestor submit documentation to support that the disputed charges rendered on February 12, 2004 were billed according to 134.202?
3. Did the requestor submit documentation to support fair and reasonable reimbursement for HCPC codes S0020, and J3301 rendered on February 12, 2004?
4. Is the requestor entitled to reimbursement for CPT codes 27096-50 and 76005?

Findings

1. Per 28 Texas Administrative Code §133.307 "(d) Timeliness. A person or entity who fails to timely file a request waives the right to medical dispute resolution. The commission shall deem a request to be filed on the date the division receives the request, and timeliness shall be determined as follows: (1) A request for medical dispute resolution on a carrier denial or reduction of a medical bill pursuant to §133.304 of this title (relating to Medical Payments and Denials) or an employee reimbursement request shall be considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute." Review of the submitted documentation finds:
    - The Medical Dispute Resolution (MDR) section received the DWC060 on November 15, 2004. Therefore date of service, April 18, 2003 was untimely filed and ineligible for review by MDR.
    - The requestor submitted date of service February 12, 2004 timely and is therefore eligible for review by MDR.
2. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." CCI edits were run to determine if edit conflicts exists for dates of service August 13, 2003 through October 31, 2003. Review of the CCI edits finds:
    - No CCI edit conflicts were identified for date of service February 12, 2004 for HCPC codes 27096-50, 76005, S0020 and J3301.
    - The disputed charges will therefore be reviewed in accordance with Rule 134.202.
3. Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used. (2) for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule. (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection. Review of the submitted documentation finds:
    - Review of the DMEPOS fee schedule (cgsmedicare.com) did not contain a fee guideline amount for HCPC codes S0020 and J3301.
    - Review of the Texas Medicaid Fee Schedule revealed that the fee schedule did not contain an established reimbursement amount HCPC code J3301.
    - HCPC codes S0020 and J3301 are therefore subject to the provisions of 28 Texas Administrative Code §134.1.

Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (6) for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor billed HCPC codes S0020 and J3301 on February 12, 2004.
- The HCPC codes indicated above does not have a Medicare or Texas Medicaid assigned value.
- Division rule at 28 TAC §134.1, effective May 16, 2002 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for HCPC codes S0020 and J3301.
- Documentation of the comparison of charges to other carriers was not presented for review.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement. Payment cannot be recommended for HCPC codes S0020 and J3301.

4. Per 28 Texas Administrative Code §134.202, "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications : (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%..."
    - The requestor billed one unit of CPT code 27096 and appended modifier 50 to identify that the procedure was performed bilaterally (left and right). The Medicare reimbursement amount for one unit is $363.39 x 125% = $454.24/unit. The requestor identified that the procedure was performed on the left and right side (-50 modifier), therefore reimbursement is recommended in the amount of $454.24 x 2 = $908.48.
    - The requestor billed one unit of CPT code 76005. The Medicare reimbursement amount for one unit is $75.00 x 125% = $93.75. The requestor is therefore entitled to reimbursement in amount of $93.75.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,002.23.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,002.23 plus applicable accrued interest per 28 Texas Administrative Code §134.803 for dates of service prior to 5/2/06, due within 30 days of receipt of this Order.

Authorized Signature

		March 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.